# Claims Clues

A Publication of the AHCCCS Claims Department January, 2004

## AHCCCS to Offer Electronic Reimbursement

AHCCCS will offer electronic payments to fee-for-service providers beginning April 1, 2004.

The new payment option will process payments using the Automated Clearing House (ACH) rather than issuing checks to providers. The ACH payment method will improve the AHCCCS Administration's overall payment service as providers will receive their money more quickly.

The Arizona Clearing House Association (ACHA) serves as the clearing house and will process electronic payments directly to the provider's bank account through Bank of America, which functions as the state servicing bank. BofA will make the electronic payment available to a provider's account one business day after the date AHCCCS transmits the ACH payments file to BofA.

The ACH process offers several benefits to providers, including:

- Elimination of mail and deposit delays
- Immediate availability of funds
- Fully traceable payments
- Elimination of lost, stolen, or misplaced checks

To begin receiving ACH payments, a provider must complete Sections 2 and 3 of the ACH Vendor Authorization form. A copy of the form is attached to this issue of *Claims Clues*.

The provider's financial institution must complete Section 4 of the form.

The form should be submitted to:

AHCCCS Finance Department
Mail Drop 5400
P. O. Box 25399
Phoenix, AZ 85002

AHCCCS will process the request by updating the vendor file. The file update may require up to two weeks depending on volume.

AHCCCS will process its normal weekly fee-for-service payment cycle and transmit the ACH payment data to BofA, which will transmit the information to ACHA. On the settlement date of the electronic payment, the provider's financial institution will credit the provider's individual account.

Providers who have questions should call (602) 417-4052 or (602) 417-4543. ❒

## Support for NSF Format to End February 29

Providers who currently submit electronic claims to the AHCCCS Administration must be certified by AHCCCS to submit HIPAA-compliant 837 claims transactions by February 29, 2004.

Electronic claims submitters have been allowed to continue to submit electronic claims in the current NSF format only if they submitted a formal contingency plan. The plan must specify the steps the submitter will take to attain compliance, conduct testing, and a time frame for attaining HIPAA compliance.

Providers who have not completed testing and certification for production submissions of the 837 to the AHCCCS program must do the following to ensure that electronic transactions are not rejected:

- Submit a contingency plan to AHCCCS prior to January 12, 2004 and,
- Complete 837 testing with AHCCCS prior to March 1, 2004.

After February 29, AHCCCS will no longer support file transmissions in the current NSF formats.

The AHCCCS Fee-for-Service program has been ready to accept and process 837 production transmissions from all trading partners who have completed required testing and are certified for production submissions since October 16, 2003, the date the HIPAA transaction standards took effect. AHCCCS also is ready to conduct 837 transmissions testing with all remaining trading partners and new trading partners.

Submitters who have questions or comments should contact the AHCCCS HIPAA Workgroup at: AHCCCSHIPAAWorkgroup@ahcccs.state.az.us. ❒

# AHCCCS Receives Grant from CMS to Participate In Payment Accuracy Measurement Pilot Project

AHCCCS has received a grant from the Centers for Medicare and Medicaid Services (CMS) to participate in the Payment Accuracy Measurement (PAM) pilot project.

This project consists of AHCCCS' review of a sampling of fee-for-service claims paid between October 1, 2003 – December 31, 2003 and the corresponding medical documentation.

A small number of AHCCCS providers may be asked to submit medical records to AHCCCS for review. The sample size for this project is modest. Providers are strongly encouraged to respond timely if asked to submit medical documentation. Cooperation will facilitate the review process and minimize the need for multiple contacts with providers. The documentation request is permitted disclosure under HIPAA privacy regulations.

This project should assist AHCCCS in identification and correction of processes that lead to claims errors. This will ultimately benefit providers.

AHCCCS appreciates your cooperation with the PAM pilot project. Providers who have questions or concerns regarding this project may contact Kyra Westlake at (602) 417-7946. ❒

# AHCCCS Covers FluMist for Three-Month Period

Due to the shortage of injectable influenza vaccine, AHCCCS will cover the intranasal influenza vaccine for dates of service from November 1, 2003 through January 31, 2004. The vaccine is marketed under the name "FluMist."

Providers should bill for the vaccine using CPT code 90660 - Influenza virus vaccine, live, for intranasal use. The vaccine is not covered under the Vaccines for Children (VFC) program, and providers should not bill 90660 with the "SL" (State supplied vaccine) modifier.

Providers may bill for vaccine administration using CPT code 90473 - Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).

The capped fee for CPT code 90660 is $51.75. The capped fee for CPT code 90473 is $4.54. ❒

# AHCCCS Approves Billing IUDs with HCPCS Codes

AHCCCS medical management has approved the use of HCPCS codes for IUDs, eliminating the need for providers to bill with NDC codes for fee-for-service claims.

Effective with claims for dates of service on and after October 1, 2002, providers must bill for IUDs on the CMS 1500 claim form using the following codes:

- J7300 - Intrauterine copper contraceptive (Paraguard)
- J7302 - Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)
- S4989 - Contraceptive intrauterine device (e.g. progestacert IUD), including implants and supplies

Rates have been established as follows:

- J7300 $ 309.60
- J7302 $355.50
- S4989 $115.04 ❒

# Nursing Facility Per Diem Rates to Increase 4%

Effective with claims for dates of service on and after February 1, 2004, fee-for-service nursing facility rates will be increased 4 per cent.

Rate schedules for nursing facilities are shown below. The rate schedules also can be found at the AHCCCS web site at: www.ahcccs.state.az.us/PlansProviders/ProcRateCodes/FeeSchedules.

The new per diem rates are:

| | |
|---|---|
| Level 1 Urban | $112.54 |
| Level 1 Rural | $109.53 |
| Level 2 Urban | $124.10 |
| Level 2 Rural | $120.46 |
| Level 3 Urban | $148.72 |
| Level 3 Rural | $144.01 ❒ |

# STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

**ACH VENDOR AUTHORIZATION**

Attn: AHCCCS FINANCE- MD 5400, P.O. Box 25399, Phoenix, AZ 85002

**Transaction Type** – Check the applicable transaction(s) and complete the sections indicated.

**SECTION 1**

**Please complete Sections 2 and 3 below; your financial institution *must* complete Section 4 prior to returning the form to AHCCCSA.**

**New ACH Setup** _____ **Change Account Type**_____ **Change Account Number**_____ **Change Financial Institution**_____

**If you are requesting a *Cancellation* , please check the box below and complete Section 2, 3, and 5**

**Cancellation Request** _____

**SECTION 2**

**PAYEE INDENTIFICATION**

**1**. Federal Employer's Identification Number (EIN) I__I__I - I__I__I__I__I__I__I__I__I

Or Social Security Number (SSN) I__I__I__I - I__I__I - I__I__I__I__I

Disclosure of your social security number is voluntary pursuant to 42 U.S.C. 405(c)(2)(C).* The State of Arizona will use your SSN or EIN to file required information returns with the Internal Revenue Service.

AHCCCS Provider Number and Locator Code:_____**This must be complete or request may be denied.**

**2**._____ **3.** ( __I__I__)-I__I__I__I-I__I__I__I__I

Payee's Name (Provider) Business Phone (Area code and number)

**4**._____ **5.** _____ _____ I__I__I__I__I__I__I-I__I__I__I__I

Address City State Zip Code

**SECTION 3**

**AUTHORIZATION FOR SETUP, CHANGES, OR CANCELLATION**

**6.** I authorize the Arizona Health Care Cost Containment System Administration (AHCCCSA) to process payments owed to me via Automated Clearing House (ACH) deposits. AHCCCSA shall deposit the ACH payments in the financial institution and account designated below.

*** I recognize that if I fail to provide complete and accurate information** on this authorization form, the processing of the form may be delayed or made impossible, or my electronic payments may be erroneously made.

I authorize AHCCCSA to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize AHCCCSA to withhold payment owed to me by

I certify that I have read and agree to comply with AHCCCSA' rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or repealed. I consent to, and agree to, comply wit

I authorize AHCCCSA to stop making electronic transfers to my account without advance notice.

I certify that I am authorized to contract for the entity receiving deposits, pursuant to this agreement, and that all information provided is accurate.

**The financial institution can process CTX payments/transactions along with addendum information. Yes _____ No_____**

| **7.Signature (Required)** | **8. Title:** | **9. Date** |
|---|---|---|
| | | |

**SECTION 4**

**FINANCIAL INSTITUTION (Must be completed by financial institution representative.)**

**10.** Bank Name:_____

**11.** Bank Address:_____ **12.** City:_____ State:_____ Zip Code: I__I__I__I__I__I-I__I__I__I__I

**13.** Routing transit number: I__I__I__I__I-I__I__I__I__I-I__I **14**. Customer account number: I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I

**15.** Type of account: **Checking** _____ **Savings** _____

**16.** _____ **17**. _____ **18.** (__I__I__)-I__I__I__I-I__I__I__I__I

Financial institution representative name (Please print): Title: Phone (Area code and number):

_____ _____

**19.** Signature (Required) **20**. Date:

**SECTION 5**

**CANCELLATION**

**21.** Reason: **22.** Date:

**SECTION 6**

**AHCCCSA USE ONLY**

**23**. Provider information verified by:_____ Does Provider have aged invoice balance? Yes_____ Amount $_____ No_____

**24.** Provider ACH Approved by:_____ Effective begin date:_____

**25.** Comments:_____

**COMPLETED BY**_____ **DATED**_____